Statewide Standard Treatment Protocol

Delaware

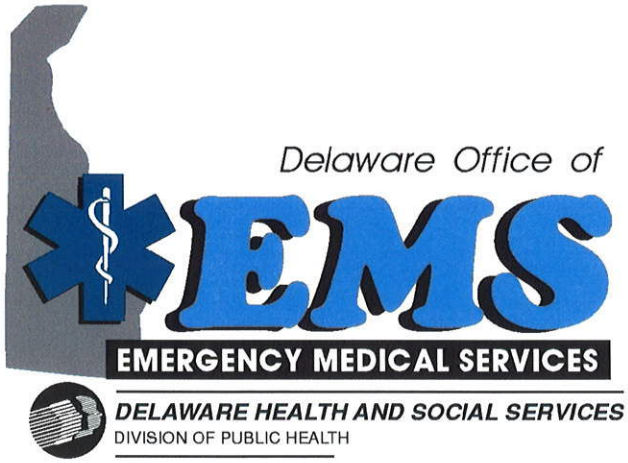
Basic Life Support Protocols, Guidelines

and

Standing Orders Mid-cycle Update

For

Prehospital and Interfacility Patients



Approved by State EMS Medical Directors: July 2013
Approved by ALS Standards Committee: September 25, 2013
Approved by the Delaware Board of Medical Licensure and Discipline: October 1, 2013

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State of Delaware
Department of Health and Social Services
Division of Public Health
Office of Emergency Medical Services,

Statewide Standard Treatment Protocols
And
Basic Life Support Standing Orders

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This treatment protocol for basic life support has been adopted and is enacted by the State Fire Prevention Commission pursuant to Delaware Code, Title 16, Chapter 98, Section 9802 (24).

David J. Roberts
Chairman
State Fire Prevention Commission

Suspect Narcotic Overdose – Narcan Pilot Protocol

Available to Select Basic Life Support Companies on Written Approval of the State EMS Medical Director or BLS Medical Director

INDICATIONS: Incomprehensible speech, inappropriate verbal responses, inability to follow verbal commands, decreased responsiveness, or unresponsiveness, respiratory distress or apnea.. This pilot protocol will allow BLS to treat patients with a history based on bystanders, providers prior knowledge of the patient or suspicion of potential narcotic overdose as evidenced by nearby medications or drug paraphernalia.

- Follow general patient care guidelines.
- Manage airway, breathing and circulation.
- Determine the appropriate response of the patient based on the developmental expectations of each age group. Enlist the assistance of the parent/caregiver or family member to determine what is "normal" for this patient.*
- Provide appropriate supplemental oxygen. Obtain a pulse oximeter reading (see pulse oximeter protocol).
- Be alert to signs of trauma on physical exam. Patients with altered mental status due to trauma should not be given anything by mouth in case their condition worsens unexpectedly or the patient requires surgery.
- Consider the administration 1 mg naloxone (Narcan®) IN (intranasal via the LMA MAD Nasal™ device) to provide for a patent, self-maintained airway and adequate respirations. If no improvement in the patient's respiratory status after two (2) minutes, a second dose of 1 mg of naloxone may be given in the opposite nares.
    - ***Caution:*** *patients with near complete reversal of a narcotic overdose may become very agitated and combative.*
    - *It is not safe to allow a narcotic overdose patient to refuse service after receiving Naloxone – contact medical control prior to a refusal of service.*
- Continue to manage the patient's airway until they are breathing adequately and are able to protect their airway from aspiration.
- Do not delay safe transport to await results of treatment.
- If there is no response to naloxone (Narcan) within five minutes consider other causes of altered mental status and proceed to alternative standing orders.
- *Obtain a blood sugar level (see BLS glucose testing policy). If the blood sugar is less than 60mg/dl and the patient is alert and able to protect their airway, use oral glucose 24 grams.*
- *If a glucometer fails or is not immediately available and patient is a known diabetic, proceed with appropriate dosage of oral glucose.*

- *If the patient is unresponsive or not alert enough to protect their own airway, paramedics or hospital personnel will need to administer intravenous glucose in order to avoid aspiration.*
- *Monitor and record vital signs. If patient's blood pressure drops below 100 mmHg systolic, treat for shock.*
- *If after 10 minutes the patient continues to be symptomatic, re-determine blood glucose level and administer a second dose of oral glucose 24 grams if glucose is still below 60mg/dl and patient is alert and able to protect their own airway.*
- *Document on the EMS patient care report the time of administration of oral glucose and any change in the patient's condition.*
- *Do not delay safe transport in order to obtain a blood glucose level.*
- A paramedic unit must assist with patient care unless the nearest appropriate hospital is closer than the paramedic unit.
- If a paramedic unit is not available, initiate transportation to a CT capable, stroke certified*** medical facility and provide a radio report to the emergency department advising them of the ETA and patient's condition.
- Contact medical control directly with any questions or concerns. Document the medical control number of the physician and any orders on the patient care report.

*Special Considerations for causes of Altered Mental Status:

A - Alcohol and abuse
E - Epilepsy, electrolytes, encephalopathy
I - Insulin
O -Opiates, overdose
U - Uremia occupying lesions, SAH
T- Trauma, temperature
I - Infection
P- Poison, Psychogenic
S- Shock, seizure, stroke, space

**Please refer to a current standard EMT textbook for a full review of altered mental status and administration of oral glucose.
***Stroke Certified by the State of Delaware or The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Refer to the county EMS Medical Director's current list of stroke certified medical facilities.

SEVERE ALLERGIC REACTION

INDICATIONS: Generalized allergic manifestations such as urticaria or history of an allergic exposure with:

- Airway obstruction (partial or complete) OR
- Clinical evidence of shock including altered mental status, confusion, delayed capillary refill, and cool, clammy, or mottled skin.

Some patients with severe asthma may manifest their allergic reaction primarily as an asthma attack.

- Provide appropriate supplemental oxygen. Obtain a pulse oximeter reading (see pulse oximeter protocol).
- Assess lung sounds during the physical examination.
- If a patient has epinephrine via auto-injector (Epi-Pen®, Epi-Pen Jr.®, or Twinjet®) prescribed by their physician, assist the patient with their epinephrine auto-injector.*
- If the patient is 25 years or younger and the BLS agency is authorized by the State EMS Medical Director to carry epinephrine auto-injector(s) on the unit, administer one dose of epinephrine via auto-injector (Epi-Pen®, Epi-Pen Jr.®, or Twinjet®) as indicated (See epinephrine auto-injector policy).**
- EpiPen® Auto-injector (adult $\geq$ 30kg / 66lbs) delivers a single 0.3 mg epinephrine dose.
- EpiPen Jr® Auto-injector (children 15-30kg / 33-66lbs) delivers a single 0.15 mg epinephrine dose.
- TwinJet® Auto-injector (adult $\geq$ 30kg / 66lbs) can deliver up to two doses of epinephrine (0.3 mg and 0.15 mg).
- Check the auto-injector to ensure the medication is not expired, has not become discolored, does not contain particulates, or sediments.
- Prep skin site with alcohol (only if alcohol is available-not necessary).
- Remove the safety cap from the auto-injector.
- Place the tip of the auto-injector against the lateral aspect of the patient's thigh midway between the waist and knee.
- Push the injector firmly against the thigh until the spring-loaded needle is deployed and the medication is injected **(AT LEAST 10 SECONDS).**

- Dispose of the auto-injector in a sharps container: **Be careful of the needle as it will now be protruding from the end of the injector.**

- Medical control should be contacted before an additional dose of epinephrine via auto-injector is administered if symptoms continue after 10 minutes.

- Medical control should be contacted before a pregnant patient receives or uses epinephrine due to the possible effect on the fetus.

- Medical control must be contacted before a patient >25 years old or a patient with known cardiac disease receives or uses epinephrine.

- Packaging and safe transport should not be delayed significantly by epinephrine administration.

- A paramedic unit must assist with patient care unless the nearest appropriate hospital is closer than the paramedic unit.

- If a paramedic unit is not available, radio a report to the emergency department advising of ETA and patient status.

- Contact the medical control with any questions or concerns regarding epinephrine therapy if needed. Document medical control physician number and any orders on the patient care report.

- Document on the EMS patient care report the name of the medication, the prescribing physician (if applicable), dose and the time of administration. A PCR MUST be submitted to the emergency department at time of patient arrival if epinephrine is administered.

*Please refer to a current standard EMT textbook for a full review of allergic reactions and administering epinephrine auto-injectors.

It is optional for BLS agencies to carry epinephrine auto-injector(s) on BLS units that were not prescribed by the patient's physician. Agencies **must follow the guidelines contained in the epinephrine auto-injector policy before placing auto-injector(s) on the unit.

GUIDELINES REGARDING DO NOT RESUSCITATE ORDERS

Living Will:*

- Living wills do not apply to out-of-hospital care.
- A living will has no impact on the decision of whether or not to initiate or continue resuscitative efforts or any other care.

Do Not Resuscitate Order (DNR):

- Contact medical control immediately.

*If a question should arise regarding DNR's, PACDs, MOLST or living wills at any time during treatment, medical control should be contacted

REFUSAL OF SERVICE

INDICATIONS: EMTs will often respond to scenes where the patient wishes to decline service. It is important that the provider obtains the patient's informed consent before leaving the scene; otherwise the provider might be exposed to legal liability for abandonment of the patient.

A patient is individual who is sick, injured, wounded or otherwise incapacitated or helpless and/or seeks immediate medical attention for whom EMS has been activated.

" Refusal of service (ROS) represents a high risk protocol for the patient and the provider. ROS subjects the patient to potential life and health risk and leaves the provider and their agency at risk for legal action. This protocol attempts to reduce risk to all parties."

All subjects of an EMS activation should be encouraged to seek care. EMS providers **shall avoid** encouraging patients (families) to refuse service. Each patient who refuses service must be fully informed about needed treatment and possible outcomes including possible disability or death, and should verbalize understanding of the risks associated with refusing the needed care. If the patient is felt to need treatment, every effort should be made to persuade the patient to consent to needed health care. Consider involving family, police, paramedics, and physician at the hospital. Strongly consider contacting medical control if the provider has any concerns regarding the welfare of the patient. Document the informed consent process, concerns, and if applicable, physician number and any orders on the run sheet and complete the approved State of Delaware refusal of service form.

- Follow general patient care guidelines.

- Take a SAMPLE history. Perform and document a primary and secondary survey. Document the patient's mental status and vital signs. If the provider assessment is refused, document this clearly.

Patients with the following conditions require contact with medical control for refusal of service. All efforts must be made to contact medical control prior to refusal of service.

- Suspicion of intoxication by drugs (prescription or legal) or alcohol, as evidenced by admission of use, odor of alcohol, unsteady gait, slurred speech, or altered mentation;

- Suspicion of suffering acutely from mental disease or have suicidal or homicidal ideation, as evidenced by hallucinations, delusions, agitation, admission or evidence of wish to do harm to self or others, or a concern from others of intention to do harm to self or others;

- Appear to be suffering from a significant head injury as evidenced by loss of consciousness, head trauma, or altered mental status;

- Appear to be suffering from hypoxia or acute respiratory distress as evidenced by abnormal vital signs, increased work of breathing, low oxygen saturation, abnormal lung sounds, or altered mental status;
- Appear to be suffering from hypoglycemia as evidenced by altered mental status, agitation, or unstable vital signs;

- Patients who are disoriented, have abnormal vital signs, or are uncooperative for any reason;

- Any intervention performed by any other healthcare provider

- A summons of EMS to a health care facility or call initiated by a health care provider

- The patient is less than 18 years old.

  All patients with the following circumstances require contact with medical control for refusal of service unless paramedics are also present and have obtained a refusal. All efforts must be made to contact medical control prior to refusal of service.

- Document the physician control number and any orders on the run sheet.

- BLS cancels ALS prior to ALS arrival

  - BLS personnel encounter a patient meeting the criteria for ALS care but no ALS is responding;

  - Medical calls dispatched as a Delta or Echo response;

  - Patients who suffer the same mechanism of injury as a Delta or Echo level trauma patient;

  - The provider feels the patient is being physically or emotionally coerced into making a decision against the patients best interests;

- Patients, who **do not meet** the criteria above, may consent to refusal of service.

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